RECP

RESIDENT ENERGY CONSERVATION PROGRAM

Navy Privatized Housing Medical Waiver Request for the Resident Energy Conservation Program (RECP)

COMPLETE THESE PAGES FOR MEDICAL WAIVER REQUESTS ONLY (Please Print)

NOTE: WOUNDED WARRIORS DO NOT COMPLETE THE REMAINING PORTION OF THE FORM.

Name of Military Resident Sponsor:

_____

Name of Resident with Health Condition (For Dependent Waiver):

_____

Service: _____ Rank: _____ Duty Station: _____

Neighborhood Name: _____

Home Address: _____

Mailing Address (If Different): _____

Home Phone: (_____)_____ Work/Cell Phone: (_____) _____

Email:_____

Purpose of this request:

☐ **MEDICAL WAIVER: I (or my dependent) am requesting a waiver from RECP due to a compromised immune system, life threatening illness or any other health condition identified in this application. Form must be completed to include medical certification and returned to Housing Service Center for processing.**

I understand that for a medical condition waiver:

1. If the doctor certifies that the resident's medical condition is permanent the waiver will remain in place as long as the resident lives in the unit. If the doctor certifies the resident's condition is temporary the resident must reapply for a new waiver if the health condition lasts longer than indicated on this application.
2. The disclosure of the personally identifiable information (PII) and/or personal health information (PHI) required by this form is completely voluntary. However, my failure (or that of my doctor) to disclose the information required by this form may result in my request for exemption being disapproved.

Signature of Military Resident Sponsor: _____ Date: _____

Signature of Adult Resident Requesting Waiver: _____ Date: _____

Return completed medical waiver request to your Housing Service Center (HSC):

Find your HSC contact information online at www.cnic.navy.mil/HousingQuickReference.

MEDICAL DOCTOR CERTIFICATION

I, _____, authorize the named health care provider to release the information specified in the below form to Navy Housing. This authorization is a one-time disclosure, only. This information will be used to verify my eligibility to receive a waiver of the payment of utilities based on a medical condition.

Provider Name: _____

Provider Address: _____

Patient Name: _____

Signature of Patient or Guardian: _____ Date: _____

Printed Name of Guardian: _____

TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPATHY (D.O.)

Your patient has applied for a waiver to pay utilities based on a declaration that they or their dependent(s) has a medical condition that is life threatening. Your review and certification will assist the Navy in processing the RECP Medical Waiver Request. Please review and complete Sections 1 and 2 as each applies to your patient's medical condition prior to providing certification in Section 3.

PATIENT NAME (Last/First): _____

Section 1. Select all life support devices below that the patient requires and uses in the home (therapy devices do not qualify). Only select devices that run on electricity or gas:

☐ Respirators (Oxygen Concentrators) ☐ Iron Lungs ☐ Hemodialysis Machines ☐ Suction Machines ☐ Compressors

☐ Electric Nerve Stimulators ☐ Pressure Pads and Pumps ☐ Aerosol Tents ☐ Electrostatic and Ultrasonic Nebulizers

☐ Kidney Dialysis Machines ☐ Intermittent Positive Pressure Breathing (IPPB) Machines ☐ Motorized Wheelchairs

☐ Other (Please list other devices not listed above and explain how the specific device(s) are used and how they are necessary to sustain the patient's life):

_____

_____

The condition is: ☐ Permanent ☐ Temporary

If Temporary, what is the estimated length of time of the health condition? : _____

Section 2. Waivers are also available if the resident has a compromised immune system, life threatening illness, or any other condition for which additional heating or cooling is medically necessary to sustain the person's life or prevent deterioration of the person's life threatening medical condition. Select all that apply:

☐ Paraplegic ☐ Quadriplegic ☐ Hemiplegic ☐ Multiple Sclerosis ☐ Scleroderma ☐ Compromised Immune System

☐ Other (Please list other medical conditions not listed above and explain how the specific device(s) are used and how they are necessary to sustain the patient's life):

_____

_____

Is the condition permanent?: ☐ YES ☐ NO

Section 3. I certify that my patient's medical condition is life threatening and requires additional utilities to sustain the patient's life or prevent the deterioration of the patient's life threatening medical condition.

Doctor's Name: _____ Phone: (_____) _____

Office Address: _____

MD/DO State License or Military License Number: _____

State of Licensure: _____

Signature of Doctor: _____ Date: _____

GENERAL PURPOSE PRIVACY ACT STATEMENT

PART A – IDENTIFICATION OF REQUIREMENT

1. REQUIRING DOCUMENT	2. SPONSOR CODE
Department of the Navy System of Records Notice NM11101-1, DON Family and Bachelor Housing Program (73 Federal Register 17334, April 1, 2008)	CNIC Regional Housing Authorities

3. DESCRIPTIVE TITLE OR REQUIREMENT

NAVY PRIVATIZED HOUSING WAIVER REQUEST FORM FOR EXEMPTION FROM THE RESIDENT ENERGY CONSERVATION PROGRAM (RECP)

PART B – INFORMATION TO BE FURNISHED TO INDIVIDUAL

1. AUTHORITY:

10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 2831, Military Housing Management Account; DOD 4165.63-M, DoD Housing Management

2. PRINCIPLE PURPOSES:

To receive information necessary to process an individual's request for exemption from participation in the Resident Energy Conservation Program throughout Navy privatized housing.

3. ROUTINE USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or the information contained therein may specifically be disclosed outside the DoD as routine use pursuant to 5 U.S.C. 552a(b)(3) to local privatized housing property managers for the proper accounting of gas and/or electric utilities charges to the individual's account.

4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT OF INDIVIDUAL NOT PROVIDING INFORMATION:

The disclosure of the personally identifiable information (PII) and/or personal health information (PHI) required by this form is voluntary. However, the failure of an individual (or of an individual's doctor) to disclose the information required by this form may have the likely negative consequence of the individual's request being disapproved for exemption from participation in the RECP program.

PART C – IDENTIFICATION OF FORM/REPORT/OTHER REQUIREMENT

1. FORM NO./REPORT CONROL SYMBOL/OTHER IDENTIFICATION	
INTERIM RECP WAIVER REQUEST	**PRIVACY ACT STATEMENT**